This information applies to all lines of business unless stated otherwise.

**Medical Policy Updates/Changes**

We’re updating the BlueCross BlueShield of Tennessee Medical Policy Manual with these new and/or revised policies. To read the complete policy information, please [click here](https://bluecross.org).

**Effective Dec. 1, 2017**

- Implantable Hypoglossal Nerve Stimulation (New)
- Noninvasive Techniques for Evaluation and Monitoring of Chronic Liver Diseases (Revision)

**Effective Dec. 20, 2017**

- Bariatric Surgery (Revision)
- BRCA1, BRCA2 and PALB2 Testing for Breast, Ovarian and Other Cancers (Revision)
- Cardioverter Defibrillators (Revision)
- Genetic Testing (CFTR-mutations) for Cystic Fibrosis (Revision)
- Osteochondral Allografting (Revision)
- Osteochondral Autograft (Revision)
- Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty (Revision)

**Effective Jan. 1, 2018**

- Applied Behavioral Analysis (ABA) (Revision)

(Prior authorization request fax forms for ABA services will be available on our website prior to the effective date of this policy.)
Prior Authorization Required for Vyxeos

Beginning Nov. 1, 2017, Vyxeos will be added to the Provider-Administered Specialty Drug Lists and will require a prior authorization for all lines of business.

You can find information on all provider-administered specialty medications requiring prior authorization on our website.

- BlueCare Tennessee
- Commercial
- CoverKids
- BlueCare Plus (HMO SNP)℠
- Medicare Advantage

Ventricular Assist Device (VAD) Dressing Supply Allowance Updated

Effective Dec. 1, 2017, supplemental information will no longer be required when filing claims for VAD Dressing Supplies billed with HCPCS Codes Q0508 and Q0509, unless specifically requested. These codes are for “miscellaneous supply or accessory for use with an implanted ventricular assist device."

Historically, VAD dressing supply allowances have been made based on the policy for codes without established fees i.e. they were determined by invoice. BlueCross has conducted an in-depth analysis of codes Q0508 and Q0509 to address provider concerns about the process to obtain reimbursement. In this analysis, we reviewed data from paid claims along with invoice documents supplied by providers to establish a reasonable allowable. This reimbursement will be a monthly rate allowance for claims filed for dates of service Dec. 1, 2017, and after.

Availity® Coming Soon

You will soon have access to the most up-to-date online tools for working with us on the Availity provider engagement portal at Availity.com. With Availity, you can interact securely with BlueCross and other participating health plans without using multiple systems. You can review remittance advices, claims status, eligibility and benefits plus these BlueCross-specific features through Availity:

- Unified Member Search – This custom member search will closely match our capabilities in BlueAccess℠ and will include search options by SSN, name and DOB.
- BlueCard® – Searches for your out-of-state patients will be available in the same interface, which means you’ll no longer have to use a separate application to view your out-of-state members (a valid ID and prefix will still be required).
- Claims Management Tool – This upgraded tool features a customized search function, so you can find rejected and adjudicated claims. You’ll also be able to see your full claim lifecycle in one place.

Availity will also feature a BlueCross-specific payer space, which offers you access to other BlueCross applications.

Watch for information soon on the actions you will need to take as we begin the migration. Be sure to select someone in your organization who will create and manage accounts. The Availity organization administrator will be responsible for setup, which includes registering the organization, setting up and assigning access to users, as well as other applicable registration and setup activities.

Your eBusiness Regional Marketing Consultant will still be your contact for training and education and will continue to lead education, provider engagement and training efforts with other BlueCross resources.
Preparing for the 2017 – 2018 Flu Season

It’s important that you help set preventive care measures to protect your patients during this time of year. Please educate all patients and parents of children older than 6 months of age on the importance of getting a yearly flu vaccine.

Please make every effort to schedule your high-risk patients for a flu shot as early as possible this flu season. To avoid missed opportunities for vaccination, you might consider offering immunizations during routine health care visits and hospitalizations.

**The following influenza immunization and reimbursement guidelines apply for BlueCross.**

**Commercial**
- **Vaccine and administration**
  The influenza vaccine, including intradermal, is a covered benefit if offered under the member’s health care plan. Please verify coverage by calling our Provider Service Line.

**BlueCare Tennessee**
- **Vaccine and administration**
  Intramuscular flu vaccine is a covered benefit for those 6 months of age and older.
  Intradermal-administered vaccine is recommended for people 18 through 64 years of age.
  Note: Flu vaccines are available through the Tennessee Department of Health’s Vaccines for Children (VFC) Program for children 18 years of age and younger. The intradermal-administered vaccine isn’t available under VFC. For more information, please call 1-800-404-3006, Monday through Friday, 8 a.m. to 4:30 p.m. (ET).

**Medicare Advantage**
- **Intradermal vaccine**
  This is a covered benefit.

**CoverKids**
- **Vaccine and administration**
  This is a covered benefit.

**Note:**
- Code 90756 will become effective on Jan. 1, 2018, for Flucelvax Quadrivalent – antibiotic-free vials (2017-2018 NDCs 70461-0301-10 and 70461-0301-12). Prior to the implementation/effective date, codes 90749 or Q2039 may be billed for this product.
- Code 90674 became effective on Sept. 1, 2016, for BlueCare, and Jan. 1, 2017, for all other lines of business for Flucelvax Quadrivalent – preservative and antibiotic-free syringes (2017-2018 NDCs 70461-0201-01 and 70461-0201-11).
Help Bust Flu Shot Myths

You play an important role in making sure our members have accurate information about flu shots. Here are some common misconceptions and answers you can share with your patients:

**It might give me the flu.**
The flu shot can’t cause the flu. Randomized, double blind studies show the only difference between the flu shot and a placebo is soreness and redness at the injection point.

**It will make me sick.**
A few people may have a low-grade fever or minor achiness, but double blind studies showed no difference in symptoms between those who received the flu vaccine and those who received a placebo.

**It won’t protect me.**
The flu shot only protects against the flu. There are several illnesses, like the common cold, that cause symptoms similar to the flu. Sometimes people develop symptoms because they are exposed to the flu before their vaccine becomes fully effective, which can take a few weeks.

New Billing Requirements for Air Ambulance Providers

New billing requirements for Commercial plans are going into effect Jan. 1, 2018, for air ambulance providers (rotary or fixed-wing):

- NPI and the appropriate taxonomy codes are required to distinguish between ground charges and air charges when filing claims.
- You must include pick-up and drop-off ZIP codes, mileage, etc.

Member cost share can be significant for this type of service, so please try to work with in-network providers.

You can find updated billing guidelines for Commercial plans in your BlueCross BlueShield of Tennessee Provider Administration Manual.

Non-Emergent Air Ambulance Transportation Requires Prior Authorization for Commercial plans*

Starting Jan. 1, 2018, prior authorization is required for non-emergent air ambulance transportation. Prior authorization won’t be required for emergency transport (e.g., from the scene of an accident when ground isn’t appropriate or would pose a threat).

To arrange non-emergent air ambulance transport for a patient with BlueCross Commercial benefits, please request prior authorization by calling BlueCross at 1-800-515-2121 (extension 6900) from 8 a.m. to 6 p.m. ET.

This prior authorization requirement may affect your patients if an out-of-network air ambulance is used for non-emergent transportation.

Coordinating Care for Patients Taking Antipsychotic Medications

Comprehensive care and coordination between primary care physicians (PCPs) and behavioral health providers is important for patients taking antipsychotic medication. Prior to starting a patient on an antipsychotic medication, consider consulting with behavioral health providers for alternative treatments, such as psychological assessment and therapy. Alternative treatment could be crucial, since some patients taking antipsychotic medication may be at risk for diabetes and heart disease.

Here are some helpful resources you can use as you determine appropriate treatment options for your patients taking antipsychotic medication:

- Call on our Behavioral Health team. We can schedule and make referrals.
- Consult with one of our Behavioral Health medical directors to discuss alternative medications by calling our Primary Care Physician Consultation line at 1-800-367-3403.
- Refer your patients to a Behavioral Health Case Manager, who can offer personal assistance with local resources, and health coaching for some plans. Here’s how your patients can reach our Behavioral Health Case Management team:
  - Commercial: 1-800-818-8581
  - BlueCare™, TennCareSelect and CoverKids: 1-888-416-3025

Please look for more information and resources in our Behavioral Health Toolkit.
Overpayment Recovery Update*

Beginning Jan. 1, 2018, BlueCross BlueShield of Tennessee will recover overpayments through an offset to the provider’s remittance advice 30 days from the date of notification. Please do not send a check for the overpayment amount. If checks are sent to BlueCross, they will be returned to the payee.

Non-Compliance Denials

Please note that non-compliance denials aren’t subject to reconsideration. However, you have 60 days to submit an appeal related to a non-compliance denial. Please complete and submit the Provider Appeal Form located on our provider webpage under the forms section. If you send the Reconsideration Form, it will delay your appeal, so be sure to use the correct form. If you need help or have questions, please call the Provider Service Line.

Tips For Coding Professionals

This information applies to all lines of business unless stated otherwise.

Using Right and Left Laterality Modifiers to Ensure Commercial Claims Payments

We want to help you make sure that your claims process efficiently and without any issues through our updated claims editing software. We will let you know when items that trigger a denial start appearing on a regular basis.

The following items require right (RT) and left (LT) laterality modifiers to process correctly:

**DME – Wheelchair Claims**

- All wheelchair accessories with a “bilateral” component require RT/LT modifiers
- All accessories billed with same code for a different level (e.g. pelvic supports, thoracic supports) require a separate line for each level
- All accessories billed with same code for front and rear components (e.g. casters) require a separate line for each section

**Drugs**

- J732x Hyaluronan or derivative codes (i.e. currently J7320 – J7328) require an RT/LT modifier if injections are made bilaterally.

**Medicare Advantage Coding for Consultation Services**

Starting Jan. 1, 2018, Medicare Advantage will no longer recognize CPT® procedure codes for consultation services (CPT® codes 99241-99245 and 99251-99255). When billing Medicare Advantage claims, you’ll be required to use the appropriate Evaluation and Management (E&M) codes when you provide services previously coded as consultations.

For office or outpatient consultations, use E&M codes 99201-99205 or 99211-99215, and 99221-9922 for inpatient consultations. Please bill your emergency department consultations as emergency department visits (99281-99285).

For more coding tips see the Code Editing section on our website.
BlueCare Tennessee

This information applies to BlueCareSM and TennCareSelect plans, excluding CoverKidsSM and dual-eligible BlueCare Plus (HMO SNP)SM unless stated otherwise.

TennCare Registration is Required for Providers to Participate in BlueCare and CoverKids Networks

Federal regulations require providers participating in our BlueCare, TennCareSelect or CoverKids networks to be registered with the Division of TennCare. Providers must have a valid, active Medicaid ID from TennCare before submitting an application to participate in the BlueCare Tennessee networks. Applications without a Medicaid ID can’t be processed.

In addition, we are required to terminate contracts with providers who are not registered with TennCare. BlueCare Tennessee members who are assigned to primary care physicians who are removed from the network will be reassigned to other network providers.

To register with the Division of TennCare please visit the TennCare Provider Registration website or if you have questions about your current registration please contact TennCare Provider Services at 1-800-852-2683 and choose option 5 or email Provider.Registration@tn.gov.

Preventing Falls Can Help Save Lives

With the support and assistance of providers like you, our goal is to help CHOICES members maintain safety during their daily activities. Falls are a major safety risk for these members. They can be costly, devastating and deadly. One in five falls causes a serious injury like a broken bone or blow to the head. They become even more dangerous if the person is taking certain medicines (like blood thinners).

What You Can Do

Usually, a fall results from the interaction of two or more risk factors. By working together with your staff, you can develop ways to keep the member’s environment safe.

Assist Members with Daily Living

By providing stand-by assistance, you can help prevent a member from falling sideways.

Medication Awareness

Know the side effects of the medications members take, especially the ones that cause dizziness.

Talk to Family Members

If you have concerns about the people you support, talk to the family. Let them know if you see an increase in falls, dizziness or balance issues and ask for their support in keeping the member’s living space free from obstacles that could cause them to fall.

Timing is Key in Reporting Critical Incidents

Critical incidents involving CHOICES members must be reported within 24 hours of discovery to Customer Service by calling 1-888-747-8955 or by email at CHOICES_CI@bcbst.com. Written reports of the incident are due within 48 hours of discovery.

Critical Incident Categories

- Death
- Major or severe injury
- Life-threatening medical emergency
- Medication error
- Safety issues
- Suspected physical, mental or sexual abuse
- Neglect (a lack of care that could harm the member)
- Theft
- Financial exploitation - improper use of funds

Follow-up reports, including provider investigation, findings and conclusion, must be submitted within 20 days from the discovery date of the incident.

The CHOICES Critical Incident forms are available at bluecare.bcbst.com. You may submit the 48-hour report and 20-day follow-up report by fax at 1-855-292-3715 or email at CHOICESQuality@bcbst.com.

In addition to reporting critical incidents involving abuse, neglect or financial exploitation to CHOICES, they must also be reported to Adult Protective Services (APS) or Child Protective Services (CPS) within 24 hours of discovery.

- APS – Phone: 1-888-277-8366 or Fax:1-866-294-3961
- CPS – Phone: 1-877-237-0004
Provider Bonus for Maternity Care

BlueCare Tennessee OB/GYN providers are eligible to earn a $10 bonus for specific Category II codes for maternity care. In order to make the submission process easier we’d like to offer a few tips on this initiative.

**When submitting 0500F, remember to:**

- Include the appropriate Evaluation & Management (E&M) Code (99201-99205 or 99211-99215) confirming pregnancy.
- Include the date of the last menstrual period in form locator 14 or Loop 2300 with Qualifier 484.
- Submit the Maternity Care Management Notification Form through BlueAccess or fax to (423) 854-6033.
- Submit at least $10 in billed charges to receive the full bonus.

**When submitting 0503F, remember to:**

- Include the postpartum code 59430.
- Include the Delivery Date in form locator 14 or Loop 2300 with Qualifier 431.
- Make sure the postpartum visit is complete within 21 to 56 days after delivery.
- Submit at least $10 in billed charges to receive the full bonus.

Please note normal third party liability (TPL) processing guidelines will still apply.

Review of 2016 ASH Claims Continues During Fourth Quarter

During the fourth quarter of 2017, we will continue our review of all BlueCare, TennCare Select and CoverKids claims submitted during 2016 that include an absolute or possible abortion, sterilization or hysterectomy (ASH). If your practice submitted an ASH claim for a procedure conducted last year, we may contact you to request records if they were not submitted with the claim.

Billing Changes for Long-Acting Contraceptives Take Effect in November

BlueCare Tennessee and CoverKids will begin reimbursing providers for voluntary reversible long-acting contraceptives (VRLAC) as separate items starting Nov. 1, 2017. Charges for VRLAC devices implanted during the labor and delivery inpatient stay must be billed as part of the inpatient claim. The following is a list of current HCPCS codes that will be affected:

- J7297
- J7298
- J7300
- J7301
- J7307
- Q9984

This change does not affect doctors who perform implants in the hospital. They will still be able to bill for their services using the CPT® code associated with the procedure.

Related information from the Division of TennCare:

- VRLAC Memo from TennCare
- VRLAC Claim Submission
Medicare Advantage

This information applies to BlueAdvantage (PPO)SM and BlueChoice (HMO)SM plans. BlueCare Plus (HMO SNP)SM is excluded unless stated otherwise.

New 2018 Benefit for BlueCross' Diabetic Medicare Advantage Members

Diabetic members will be able to take advantage of a new Medicare Diabetes Prevention Program (MDPP) starting in 2018. Through a partnership with Solera Health, members at risk for developing diabetes can learn how to make lasting changes by eating healthier, increasing physical activity and managing the challenges that come with lifestyle change.

MDPP is free to qualifying members and includes:

- Sixteen weekly lessons, followed by monthly sessions for the rest of the year
- A lifestyle health coach who will help set goals and keep participants on track
- Small groups for support and encouragement
- Helpful tools, like wireless scales and fitness trackers

You will be able to refer your patients to the program through BlueCross’ Population Health program. Additional details on referring patients will be included in a future edition of BlueAlert.

BlueChoiceSM No Longer Offered in 2018

While BlueCross will continue to offer our BlueAdvantageSM plan in 95 counties across Tennessee in 2018, we will no longer offer our BlueChoice HMO. A majority of our Medicare Advantage members are enrolled in our PPO and will not be impacted by this change.

We sent our BlueChoice members a letter in early October announcing this change and gave them the option to enroll in BlueAdvantage for 2018. BlueAdvantage has similar benefits including prescription and limited dental coverage within a larger provider network. We also encouraged them to call the number on the back of their identification card to speak with our customer service team if they had any questions. If you have questions, please call our Provider Service line.

Flu Vaccines Keep Your Patients Healthy

With flu season in full swing, remind your patients to get their annual flu shot. It’s quick, easy and included in the benefits for BlueCross Medicare Advantage members. Most important, it can help keep them healthy.

Patients 65 and older are at greater risk for serious complications from flu. Because our immune system weakens as we age, almost 90 percent of flu-related deaths happen
in patients older than 65, along with nearly 60 percent of hospitalizations for this same age group. The flu shot is a calendar-year benefit, so it’s covered once a year regardless of the number of days between vaccinations.

Your senior patients may receive the regular or newer higher dose vaccine. The higher dose vaccine is 24 percent more effective in those who are 65 and older according to The New England Journal of Medicine.

This time of year is also a good time to review your patient’s pneumococcal vaccine status.

**High-Tech Imaging “C” HCPCS Code Cross-Reference Document**

A new reference document is available to help manage “C” codes for outpatient facilities related to high-tech imaging requests. CMS created the codes for their outpatient facility to augment reimbursement when paying on a per-diem basis. The codes were not created to represent “base” procedure codes like CPT®, “G” or “S” HCPCS codes.

Authorizations are performed on the specific CPT®, “G” or “S” code not based on “C” codes. If a “C” code is submitted for claim payment, it must have an existing authorization on file with the appropriate base procedure code to ensure claim payment. Download the BlueAdvantage & Blue Choice Cross-Reference Table from our Provider page at bcbst.com.

**New In-Home Screening Vendor – Matrix Medical Network**

Starting Nov. 1, 2017, BlueAdvantage members who have been identified as having gaps in care will be able to receive in-home screenings by Matrix Medical Network, our newest in-home health care vendor.

Matrix will schedule in-home assessments, including bone mineral density screenings, diabetic retinal eye examinations, FIT testing for colorectal cancer and hemoglobin A1C measurements for diabetic patients. These are all screenings that link directly to the Medicare Advantage Stars program.

Matrix will send copies of all test results to each member’s primary care physician of record. Please email Jodi (Hazel) Bolen, Manager of Stars Member Experience, if you have questions about this program.

**Prior Authorization Required for Medicare Advantage and BlueCare Plus℠**

As a reminder, beginning Oct. 1, 2017, prior authorization is now required for the provider-administered specialty medications listed below for the Medicare Advantage and BlueCare Plus plans.

**Specialty Medications Requiring Prior Authorization (Effective Oct. 1, 2017)**

<table>
<thead>
<tr>
<th>Specialty Medication</th>
<th>Provider Administered Specialty Medication</th>
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</thead>
<tbody>
<tr>
<td>Abraxane</td>
<td>Benlysta</td>
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<tr>
<td>Acthar HP</td>
<td>Berinert</td>
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<tr>
<td>Adagen</td>
<td>Cerezyme</td>
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<tr>
<td>Adcetris</td>
<td>Cimzia</td>
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<td>Aldurazyme</td>
<td>Cinryze</td>
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<td>Aloxi</td>
<td>Cyramza</td>
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<tr>
<td>Aralast/Prolastin/</td>
<td>Elelyso</td>
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<tr>
<td>Prolastin C / Zemaia</td>
<td>Eligard / Lupron Depot</td>
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<tr>
<td>Arranon</td>
<td>Empliciti</td>
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<tr>
<td>Arzerra</td>
<td>Epoprostenol (Flolan/Veletri)</td>
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<td>Beleodaq</td>
<td>Fabrazyme</td>
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<td>Firmagon</td>
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<td>Folotyn</td>
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<td>Fusilev</td>
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<td>Gazyva</td>
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<td>Glassia</td>
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<td>Halaven</td>
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<td>Ilaris</td>
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<td>Kadcyla</td>
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<td>Kanuma</td>
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<td>Krystexxa</td>
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<td>Kyprolis</td>
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<td>Lumizyme</td>
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<td>Lupon Depot</td>
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<td>Marqibo</td>
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<td></td>
<td>Naglazyme</td>
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<td>Onivyde</td>
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<td>Ozurdex</td>
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<td>Perjeta</td>
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<td>Proleukin</td>
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<td>Vantas</td>
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<td>Ruconest</td>
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<td>Vimizim</td>
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<td>Signifor_LAR</td>
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<td>Temodar (IV)</td>
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<td>Trelstar Depot</td>
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<td>Tyvaso</td>
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<td>VPRIV</td>
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<td>Xiaplex</td>
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<td>Zaltrap</td>
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<td></td>
<td>Zoladex</td>
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<td>Sylvant</td>
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</table>

You can find information on all provider-administered specialty medications requiring prior authorization for each line of business on our website.
Quality Care Partnerships

This information applies to all lines of business unless stated otherwise.

2018 Medicare Advantage Quality Care Partnerships Performance Measures

Our Medicare Advantage (MA) plans will be sending quality amendments for 2018. Below is an updated list of planned measures. Please speak with your Quality Incentive Consultant if you have any questions.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Type</th>
<th>Weight</th>
<th>1 Star</th>
<th>2 Star</th>
<th>3 Star</th>
<th>4 Star</th>
<th>5 Star</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult BMI Assessment (ABA)</td>
<td>Process (Non-Continuous)</td>
<td>1</td>
<td>&lt;43%</td>
<td>43%</td>
<td>62%</td>
<td>90%</td>
<td>98%</td>
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<tr>
<td>Breast Cancer Screening (BCS)</td>
<td>Process (Non-Continuous)</td>
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<td>&lt;45%</td>
<td>45%</td>
<td>65%</td>
<td>71%</td>
<td>78%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (COL)</td>
<td>Process (Non-Continuous)</td>
<td>1</td>
<td>&lt;60%</td>
<td>60%</td>
<td>64%</td>
<td>73%</td>
<td>84%</td>
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<tr>
<td>Comprehensive Diabetes Care (CDC) – Eye Exam (Retinal) Performed</td>
<td>Process (Non-Continuous)</td>
<td>1</td>
<td>&lt;48%</td>
<td>48%</td>
<td>63%</td>
<td>75%</td>
<td>83%</td>
</tr>
<tr>
<td>Medication Reconciliation Post-Discharge (MRP)</td>
<td>Process (Non-Continuous)</td>
<td>1</td>
<td>&lt;20%</td>
<td>20%</td>
<td>34%</td>
<td>57%</td>
<td>70%</td>
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<tr>
<td>Comprehensive Diabetes Care (CDC) - HbA1c Control (&lt;9.0%)</td>
<td>Outcome (Continuous)</td>
<td>3</td>
<td>&lt;51%</td>
<td>51%</td>
<td>64%</td>
<td>78%</td>
<td>86%</td>
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<tr>
<td>Comprehensive Diabetes Care (CDC) - Medical Attention for Nephropathy</td>
<td>Process (Non-Continuous)</td>
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<td>&lt;94%</td>
<td>94%</td>
<td>95%</td>
<td>97%</td>
<td>99%</td>
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<tr>
<td>Controlling High Blood Pressure (CBP)</td>
<td>Outcome (Continuous)</td>
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<td>&lt;40%</td>
<td>40%</td>
<td>58%</td>
<td>66%</td>
<td>77%</td>
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<tr>
<td>Medication Adherence for Cholesterol (Statins)</td>
<td>Outcome (Continuous)</td>
<td>3</td>
<td>&lt;67%</td>
<td>67%</td>
<td>74%</td>
<td>79%</td>
<td>84%</td>
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<tr>
<td>Medication Adherence for Hypertension (RASA)</td>
<td>Outcome (Continuous)</td>
<td>3</td>
<td>&lt;73%</td>
<td>73%</td>
<td>77%</td>
<td>81%</td>
<td>85%</td>
</tr>
<tr>
<td>Medication Adherence for Oral Diabetes Medications (OAD)</td>
<td>Outcome (Continuous)</td>
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<td>78%</td>
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<tr>
<td>Plan All-Cause Readmissions (PCR)</td>
<td>Outcome (Continuous)</td>
<td>3</td>
<td>&lt;13%</td>
<td>13%</td>
<td>10%</td>
<td>8%</td>
<td>6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Type</th>
<th>Weight</th>
<th>1 Star</th>
<th>2 Star</th>
<th>3 Star</th>
<th>4 Star</th>
<th>5 Star</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)</td>
<td>Process (Non-Continuous)</td>
<td>1</td>
<td>&lt;55%</td>
<td>55%</td>
<td>74%</td>
<td>77%</td>
<td>82%</td>
</tr>
<tr>
<td>Osteoporosis Management in Women Who Had a Fracture (OMW)</td>
<td>Process (Non-Continuous)</td>
<td>1</td>
<td>&lt;23%</td>
<td>23%</td>
<td>36%</td>
<td>53%</td>
<td>72%</td>
</tr>
</tbody>
</table>

NOTE: Measures and cut points for the MA Star Ratings Program are determined by CMS and are based on prior year performance of all MA plans. To adjust for industry improvement in the upcoming year, BlueCross retains the right to adjust the cut points based on statistical analysis of industry trends from prior years’ performance.
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Changes will be included in the next provider administration manual update as applicable. Until then, please use this communication to update your provider administration manual.

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- Update your provider profile on the CAQH ProView™ website.

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Commercial UM 1-800-924-7141
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Federal Employee Program 1-800-572-1003
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TennCare Select 1-800-276-1978
CoverKids 1-800-924-7141
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ECF CHOICES 1-888-747-8955
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Phone: Select Option 2 at (423) 535-5717
Email: eBusiness_service@bcbst.com
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